**Envoy Medical Systems, LP**
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**IRO Certificate #4599**

DATE OF REVIEW: 6/10/16

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Outpatient Surgery: Arthroscopic shoulder with RCR, Biceps Tenodesis, Subacromial Decompression, Distal Clavicle Resection, CPT: 23430, 29824, 29826, 29827

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

| | | |
|---|---|---|
| **Upheld** | **(Agree)** | **X** |
| Overturned | (Disagree) | |
| Partially Overturned | (Agree in part/Disagree in part) | |

PATIENT CLINICAL HISTORY SUMMARY
Patient is a man initially injured on the job in XX/XXXX. The description of the accident was described as a XXXXX hitting his shoulder resulting in a left shoulder injury. He was seen by another physician and eventually underwent surgery for a rotator cuff tear in XX/XXXX. Apparently, he had continuing difficulties despite postoperative therapy and was sent for a repeat MRI (X/X/XX). He was referred to the treating physician for a recurrent rotator cuff tear. Physical examination at that time showed tenderness over the left shoulder. AC joint mildly tender. Range of motion reveals external rotation about 35-40 degrees. Abduction is 60 degrees. “Adducted” external rotation 70 degrees. Pain with elevation. Supraspinatus strength only 4/5. Subscapularis strength intact 5/5. Discussion with patient felt he was a candidate for repeat repair. The surgeon recommended biceps and distal clavicle treatment in the setting of a recurrent tear. Patient initially in agreement and plans were made for “comprehensive” treatment of the shoulder. Subsequent visit on X/X/XX states patient remains off work and is scheduled for rotator cuff repair. PA visit on X/X/XX reports patient is still having problems, and would like to discuss surgery, but would like to have injection placed in the interim. Plans for preoperative clearance were made. PA visit on XX/X/XX revealed patient got 100% relief of his pain initially, but pain returned soon after injection. Patient still interested in surgical treatment. Risks of operative and nonoperative treatment were once again discussed. Subsequent visit with treating physician on X/X/XX with pain continuing. Patient is still interested in surgical treatment. Prior therapy and activity modification noted is unsuccessful. No physical examination of the shoulder took place. A review of MRI study dated X/X/XX shows recurrent tear. No mention of other studies. Surgeon requesting appeal to be reconsidered as patient has “waited quite some time to have this done definitively”.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
**Opinion: I agree with the benefit company's decision to deny the requested service.**
Rationale: Previous reviews and denials were based upon failure of the the treating physician to document both objective radiographic evidence of a recurrent tear, and an appropriate physical examination. While I agree that the most recent physical examination by the treating physician is completely inadequate, as it does not include an examination of the shoulder, I *do* believe the initial

physical examination performed on X/X/XX would have been sufficient as documentation for the planned procedure. In addition, the treating physician was using a previous study as the basis for his radiographic evidence of a recurrent full-thickness tear of the supraspinatus (X/X/XX), and made no mention of a more recent study (X/XX/XX) that showed evidence of only a partial tear of the supraspinatus. It appears as though previous reviewers did not have access to the MRI report dated XX/XX/XX. Furthermore, it is curious to me that the most recent MRI (XX/XX/XX) describes nothing to suggest previous surgery, leading me to question the accuracy of that interpretation. In summary, I agree with the current denial of services because of inadequate documentation of a detailed physical examination of the shoulder and review of the available studies, but would possibly reverse my opinion with additional supporting diagnostic documentation.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X**

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)